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Enabling children: participation as a new perspective on child-health promotion

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Summary

As fellow citizens, all children need a stimulating social environment that helps them develop self-respect and social competence. Developmental research, however, shows, that many children do not or cannot fulfil the social, moral or cognitive developmental tasks which are necessary for healthy development. A lack of opportunities for gaining meaningful social experiences can be seen as a major source of psychosocial and behavioural problems in children. On the contrary, active commitment in educational environments such as the school and the neighbourhood, helps them to get an increasingly better grip on their own lives and health. Moreover, such 'children's participation' appears to have a protective and preventive effect for health-related problems. Therefore, it is argued, that 'enablement', a key-element of both the Ottawa Charter on Health Promotion and the International Convention on the Rights of the Child, should be at the core of every child-health promotion programme.

Keywords: child-health promotion, child development, children's participation

Introduction

The Ottawa Charter of 1986 defined health promotion as 'the process of enabling people to increase control over, and improve their health'. With respect to health promotion in children and youngsters a lot has been accomplished since that time. Many educational programmes have been developed to teach children healthy behaviour, it has become rather common to pay attention to children's physical and social environment as related to health, and increasingly we can observe the development of intersectoral child health policies. However, with respect to one of the Charter's key elements, namely the

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active participation or 'enablement', child-health promotion finds itself in an embryonic phase. The dominant approach is still 'top-down', meaning that professionals themselves establish how to educate young people, and that health-policy makers are concerned with creating healthy environments — naturally, always in good, intersectoral co-operation. The question is: where are the children? What is the health-promoting effect of keeping children in the role of passive consumers, as the objects rather than subjects of well-meant services and programmes?

In 1990 the UN Convention on the Rights of the Child came into effect. Apart from articles on the traditional child-care topics of protection and provisions, for the first time in the history of international human rights' conventions the convention comprised a number of obligations on the right of participation by children and youngsters. The main articles concerned are nr. 12 (the right to express views in matters affecting the child), nr. 13 (the right to freedom of expression), nr. 14 (the right to freedom of thought, conscience and religion), and nr. 15 (the right to freedom of association and assembly).

The argument presented in this article is that both the Ottawa Charter's perspective of enablement and the participatory rights of the UN convention have a clear foundation in the psychological and social needs of children and society. Helping children to articulate their opinions on their environment, stimulating them to develop social responsibility appears to be a crucial, but often forgotten factor in the prevention of psychosocial problems and the promotion of health and well-being. Therefore, a serious dialogue with children in matters concerning their own quality of life, in other words, encouraging children's participation, should both be considered as a basic right, and as a precondition for the promotion of health and well-being.

Participation and development

The development of children and young people could be described as a process of mutual interaction between the individual and his/her environment. It takes place within a culturally determined field, in which 'the growing psychological properties of a child are a response to the physical, cultural and social circumstances, challenges and obstacles which it encounters' (Elbers 1993:p. 83; Valsiner 1987). Thus, the possibilities and limitations that the environment offers children, channel the developmental process. In recent years various child and developmental psychologists have pointed out that many children encounter difficulties fulfilling some of the developmental tasks set to them. It is thought that their environment offers them too little room for learning and

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development. The expansion and facilitation of these possibilities are now seen as a measure that serves to prevent psychosocial problems and behaviour disorders. Participation thus becomes a means of realizing these developmental tasks. Research into moral, emotional, cognitive and social development provides good psychological arguments for strengthening the active participation of children. A wide area of 'individual' problems should be considered as the result of 'cultural practices in which children and young people are not, or not always, taken as serious actors' (Heymans 1992). For example, styles of upbringing (both within and outside the family) in which power differences are continuously stressed (the so-called authoritarian style) appear to have an inhibiting effect on social, emotional and moral development. On the contrary, educational patterns which allow children a serious voice and an active role in managing their environment appear to provide an important resource for healthy development (Selman 1976; Diekstra 1992). Damon (1988; p. 146), for example, shows that morality is learned particularly through active participation in the 'natural context of tangible social interactions': 'For a child, the outcome of a social engagement — its developmental ''message'' — is determined more by the quality and method of the child's participation than by ideas to which the child might be exposed'. Hart (1992) emphasizes the importance of children's participation for the development of autonomy and social co-operation. If children are engaged in projects they feel connected to and involved with, they discover that dialogue and negotiation with other children and with adults is indispensable. This 'learning to work together' is in turn a precondition for the development of autonomy.

Mental health and well-being

Findings from studies into factors that influence mental health show the importance of social participation from a different perspective. They lead to the conclusion that social-psychiatric disorders do not only originate in the built-in impossibilities of the individual, but also in his relationship with his immediate environment, and (on a macro level) in society as a whole (for example Gastelaars 1991). Consequently, one of the basic conditions for social survival is the possibility of belonging in an environment that offers sufficient common ground for personal commitment (ibid). Accordingly, the incidence of psychosocial disorders, also in young people, can, at the very least, be reduced by the strengthening of social commitment (De Ridder 1988). A rich literature that has developed with respect to so-called 'determinants' of mental health provides us with important leads for this

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proposition. The way people learn to cope with events and circumstances in their lives, apart from the nature and gravity of these conditions themselves, appears to greatly influence their psychosocial well-being. The process of coping refers to 'cognitive or behavioural attempts to master internal and/or external demands that arise from stressful interaction' (Folkman & Lazarus 1988). Personality traits such as hardiness, resilience and a sense of coherence play a major role in this process. *Hardiness* can be described as 'a cognitive personality factor that causes situations to be perceived as being less stressful' (Bosma & Hosman 1990). People in whom this trait is sufficiently well-developed are characterized by: (a) *commitment* (i.e. they consider it meaningful to be occupied with a problem or with situational change), (b) *a sense of control* over one's own life situation (also called mastery or internal locus of control), and (c) an attitude that enables the individual to see changes in the environment as a *challenge,* a stimulus to further development. Related to this are concepts such as *resilience* ('hardiness and flexibility in problem situations') and a *sense of coherence*. Antonovsky (1979) describes this latter trait as 'an all-pervasive, durable yet dynamic sense of trust that one's external environment is predictable and that things will most probably turn out as well as they can reasonably be expected to'. It is generally assumed that an adequate style of coping increases the chance of psychosocial well-being. 'Positive' traits, attitudes and convictions in a person reinforce the quality of the coping process and thus, the well-being of that person. Various studies confirm, for example, the relationship between the degree of hardiness and the occurrence of illness at a time of great stress (Schrameijer 1990). When people have the feeling that they themselves can control circumstances and events (an internal locus of control), they seem to be more inclined to adopt an active attitude with respect to any problems that may occur. Conversely, people who have the feeling that everything in life 'happens to them' (an external locus of control) present more passive behaviour when they meet with adversity.

Various surveys that have been done over the past years on the effectiveness of *prevention programmes* for health problems in young people confirm the importance of children's participation, as a tool to develop effective coping-mechanisms (cf. Price *et al.* 1988; Bosma & Hosman 1990). In this connection, Slot (1988) speaks of a 'social competence model', as contrasted with the so-called 'deficiency model' that still largely determines the way of thinking and acting in child (health) care. The social competence approach tries to enlarge the extent to which a young person is capable of responding adequately in his day-to-day contacts. Children's living environments, such as the school and the

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neighbourhood, therefore should be arranged in such a way they are evoking competent behaviour. From these studies it can be concluded that children's participation should be both objective and the means of child-health-promotion. Programmes gain in effectiveness when young people are enabled to help each other gain social skills, when they are increasingly offered more joint responsibility for their mutual living environment (Jagers & Slot 1993).

Health promotion in schools and neighbourhoods

In view of the above, the active involvement of young people in their living environment can be expected to have considerable health-promoting value. Not treating them as dependent objects of adult interventions, but involving them as active and competent subjects in (the planning of) interventions, as well as in the arrangement and management of the living situation, can also give these children the feeling that they can master their lives and their health. Many of the programmes aimed at child-health promotion are situated within schools (healthy schools) and neighbourhoods (healthy cities). We will briefly discuss both contexts from the perspective of children's participation, as outlined above.

Modern schools are highly developed and highly professionalized institutions, mostly rather unilaterally directed at the cognitive development of children. One of the unintended consequences is that the school can be seen as a major source of psychological problems in children, such as fear of failure, loss of interest, depression, etc. There is a strong connection between such problems on the one hand, and widely spread phenomena like school drop-out, delinquency, etc. on the other hand (van der Linden 1990). The English psychologist Margaret Donaldson showed, more then a decade ago, how this process of *demoralizing* school children is operating. According to her, many of the inherent and acquired social and cognitive skills that children have when they enter school, are not being utilized in an adequate way. They are asked to solve problems and tasks they do not always understand. Therefore many children don't develop a full consciousness of their own intellectual and social capacities, and so they are unable to develop a sufficient sense of control over their own thinking and actions. Donaldson concluded that children are kept dependent too much and too long in different areas, and so they are denied the necessary experiences to develop their capacities for initiative and responsible action. The result of this is that a considerable number of children give up early their fundamental humanitarian need to develop themselves into effective, competent and independent individuals (Donaldson 1978). Many health-

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orientated programmes have been aimed at the prevention of such problems, mainly by trying to implement early identification instruments like screening for fear of failure, depression etc. (de Winter 1996). Health-promotion, however, implies a proactive perspective: the heart of the matter is to give children more space to practise social skills and responsibilities, inside and outside school. Research shows that such room for experience not only promotes social, cognitive and moral development, but is also able to prevent all kinds of psychological problems in terms of well-being and health. Active participation in school creates the feeling of being important, being welcome and being appreciated. It stimulates the formation of a social attachment, and it can be considered as major source of child-health promotion (Matthijssen 1991; Hart 1992; de Winter 1996).

Also, the *neighbourhood* in which a child grows up is an important field for personal and social development. Once again we will concentrate upon the amount of social participation children are allowed. Recent studies showed that children are mostly treated as 'objects' of local welfare-policies. That means policies about provisions and facilities for children and youth are designed, *without* involving or consulting them (de Winter 1996). One does not seem to realize that young people, like adults, want to be taken seriously when matters of their own interest are concerned.

For example, playgrounds are designed and built *for* children, not *with* children. Programmes to prevent intolerance between different ethnic groups, to prevent environmental pollution, or to promote traffic-safety in the neighbourhood, treat youth as a *target-group*, not as a group of persons concerned, with whom a *dialogue* should be started. From the perspective of child-health promotion this attitude is to be concerned as a fundamental mistake. This way children learn from a young age that they are not being considered as important social subjects, whose opinions and involvement really matter. On the contrary: they are clearly given the message that they are apparently not worth listening to; they learn that the institutions of society are an anonymous entity that think and decide for them. From a developmental point of view this denial of children's participation is to be considered as a risk-factor for adequate social and moral development, as well as for the emergence of psychological problems. Formulated in a positive way: children's participation in local health projects should be considered as a *protective condition* for individual development, health and well-being, and as a necessary condition for social integration. This protective condition thus can be considered as the heart of every neighbourhood-orientated child-health promoting programme.

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Enabling children: a key to health promotion

Recent theories on children's social, intellectual and moral development focus on the importance of the individual's own activity and responsibility with regard to their developmental environment. Learning to be in charge over one's own life, and learning to act as a valued member of one's own social network appears to be an underestimated factor in the emergence of health and well-being. Promoting optimal social, moral and cognitive development means creating an environment in which children and youth get the chance to participate actively in matters that are relevant and important to them. The level of participation should, of course, depend on their developmental possibilities. This developmental level, however, should not be used as an excuse to exclude children from active social roles, as is frequently the case. Children's participation appears to be a powerful instrument to raise the current level of functioning. Many of the developmental environments we offer children are counter-productive in this respect. We can observe a widening gap between education taking place in families on the one hand, in which listening to children, consulting them and negotiation seems to develop into a modern standard; on the other hand in the public sphere there is a tendency in just the opposite direction, namely excluding children from relevant social experiences which are an absolute prerequisite for individual and social education.

Adults, especially those concerned with youth-care and youth-policies, should realize that protecting children does not mean denying them the possibilities to learn to be a part of our world. Learning by doing, learning by participation in stead of exclusion is to be concerned as a powerful tool to promote self-confidence, self-respect and a sense of control over one's own life.

According to the World Health Organization about 500 million people in the world suffer from serious mental problems like neurosis, psychosis and depression. In The Netherlands different recent studies showed that about 10–15% of all youth have moderate to serious psychological and social problems. Therefore, professionals and policy-makers should develop collective strategies, aimed at promoting positive, safe and stimulating developmental environments for children and youth to grow up in. Treating children as a potential problematic category, in schools, in neighbourhoods and in health-promoting programmes can be seen as a social and cultural risk-factor in itself. This cultural attitude seems to be undermining the developmental, psychological and social potentials that are needed for growing up as balanced individuals with a positive 'habitat' fostering society and citizenship. Thus, a very important aspect of promoting children's well-being is helping to create

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developmental environments which give children a voice, which consider them as citizens-to-be in need of a significant and meaningful social role. Professionals working for schools, neighbourhood health-programmes or welfare-programmes in general could facilitate this attitudinal change. On the one hand they can show how the lack of meaningful social experience forms a clear hazard for psychological health, on the other hand they could demonstrate how the empowerment of children and youth contributes to constructive adulthood, both in a psychological and a social sense. The message thus is: don't develop programmes *for* children, but *with* them.

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Commentary

De Winter, Baerveldt and Koooistra make a cogent case for the need for children's participation in society to be increased as a way of improving their health. It is very helpful for the arguments to be set out so clearly as they have by no means been accepted or even addressed by those who will take decisions in the education system, social services, health services and central government. Linked issues here are the development of self-esteem, of an internal locus of control and of empowerment: buzz words that continually appear in health promotion documents yet are very hard to translate into reality. Empowerment of children and young people is particularly difficult in the educational system, which is rooted in the principles of teacher control. The authors describe the work of Margaret Donaldson on how schools

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'demoralize' children. I first heard this view expressed in the writings of John Holt (1967) who wrote at length on the issues of school repression of children's creative capacities in the US in the 1960s. Nothing has changed in the educational system and experimental approaches are discouraged in the present climate of pressure towards academic rather than social targets. In UK schools there is repression rather than participation: the application of national targets rather than the development of individualized programmes, and the return to rote learning rather than learning by doing. In a consultation with young people in Newcastle upon Tyne, a northern English city with high rates of poverty and unemployment, they place stress and mental health problems at the top of their list of health priorities and stated that the unwelcoming school environment is one of the reasons (PEG 1997).

So, seemingly we are not in a favourable climate for developing participation. Yet all is not doom and gloom. The UK's ratification of the UN Convention on the Rights of the Child (British Association for Community Child Health 1996) has lead to a greater awareness and models are being developed, including a national UK organization called Article 12. The Department for Education and Employment has included a young person on a committee to develop the personal and social education teaching in the national curriculum. There is, however, a great risk of tokenism and lip service being applied to young people's participation. How can health professionals, who are in a good position to promote young people's involvement in health promotion, do more to make the participation real?

1 Ensure that there is *consultation* with children and young people over the development of new services. Methods are now well established (Hart & Chessan 1998) for doing this and there is every reason for making consultation a routine when opening a new children's outpatients or changing the focus of the school health service. The same priniciple should be applied by social services and (eventually) by schools.

2 Develop a mechanism for helping young people to take part in the *planning* of services. There will be much more resistance to this than to consultation and we need to seek young people's assistance in showing us the best ways of doing this.

3 Make use of young people in *training* exercises, to demonstrate to adults how to talk to young people and how to work with them.

4 Develop *peer education programmes.* These make use of young people's skills as educators in health promotion in high risk areas such as sexual health and substance abuse. There is much experience of this effective technique in the

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USA. Similarly *child-to-child* (Aarons & Hawes 1979) is an effective educational programme with younger children, in which children become health advocates and motivators towards other children and families.

5 Be *advocates* for young people and their need for participation so that the matter can be raised appropriately in committees and decision–making structures.

De Winter and colleagues make a strong case but young people are not in a powerful position, and require support among those who work with them to press for participation at every level.

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